

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44099

STATE FILE NUMBER

FILED DEC 30 1957

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1175-0

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield		c. CITY OR TOWN Springfield	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Handley Hosp.		Length of stay in lb Life.	
d. STREET (Parents) ADDRESS 1110 E. Scott		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle ----- Last Schneider		4. DATE OF DEATH Month Dec. Day 7 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) 15
11. BIRTHPLACE (City and state or country) Springfield, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Charles Albert Schneider, Jr.		13b. MOTHER'S MAIDEN NAME Anita LaVonne Toombs	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Charles Schneider	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) immature (5 1/2 mos viability)		INTERVAL BETWEEN ONSET AND DEATH 10 min	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) premature labor & placental detachment		DUE TO (c) -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7615		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour ----- Month, Day, Year a.m. ----- p.m. -----		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY ----- STATE -----	
21. I attended the deceased from Dec. 7-57 to Dec. 7-57 and last saw her alive on Dec. 7-57 Death occurred at 5:40 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE M. G. Gentry (Degree of title) M.D.	
22b. ADDRESS Springfield, Mo.		22c. DATE SIGNED 12-12-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12-10-1957	23c. NAME OF CEMETERY OR CREMATORY Green Lawn	23d. LOCATION (City, town, or county) (State) Springfield Mo.
24. FUNERAL DIRECTOR Samuel ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 12-20-57	
26. REGISTRAR'S SIGNATURE Edith Wallman			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 3312

P. O. Address Springfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.